

UNCLASSIFIED//FOR PUBLIC RELEASE

**MILITARY COMMISSIONS TRIAL JUDICIARY  
GUANTANAMO BAY, CUBA**

**UNITED STATES OF AMERICA**

**v.**

**KHALID SHAIKH MOHAMMAD;  
WALID MUHAMMAD SALIH  
MUBARAK BIN ‘ATTASH;  
ALI ABDUL AZIZ ALI;  
MUSTAFA AHMED ADAM  
AL HAWSAWI**

**AE 960A (GOV)**

**Government Notice  
Of Proffer of Testimony for  
Dr. [REDACTED]**

23 August 2024

**1. Timeliness**

This Notice is timely filed.

**2. Notice**

The Prosecution hereby notifies the Commission of the attached affidavit and curriculum vitae of Dr. [REDACTED] which was provided to the Defense on Monday, 19 August 2024. *See* Attachs. B–C. The affidavit provides a proffer of Dr. [REDACTED] expected testimony in rebuttal of Dr. David Hanrahan, a Defense expert witness. Dr. [REDACTED] is expected to testify from the Remote Hearing Room between 23–24 September 2024.

**3. Attachments**

- A. Certificate of Service, dated 23 August 2024.
- B. Affidavit of [REDACTED] Ph.D, dated 19 August 2024.
- C. Curriculum Vitae of [REDACTED] Ph.D.

Respectfully submitted,

/s/

Clay Trivett  
Managing Trial Counsel

Christopher M. Dykstra  
Deputy Managing Trial Counsel  
Office of the Chief Prosecutor  
Office of Military Commissions

# ATTACHMENT A

**CERTIFICATE OF SERVICE**

I certify that on the 23rd day of August 2024, I filed AE 960A (GOV), Government Notice Of Proffer of Testimony for Dr. [REDACTED] with the Office of Military Commissions Trial Judiciary and I served a copy on counsel of record.

//s//

Christopher M. Dykstra  
Deputy Managing Trial Counsel  
Office of the Chief Prosecutor  
Office of Military Commissions

# ATTACHMENT B

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MILITARY COMMISSIONS TRIAL JUDICIARY  
GUANTANAMO BAY, CUBA

UNITED STATES OF AMERICA

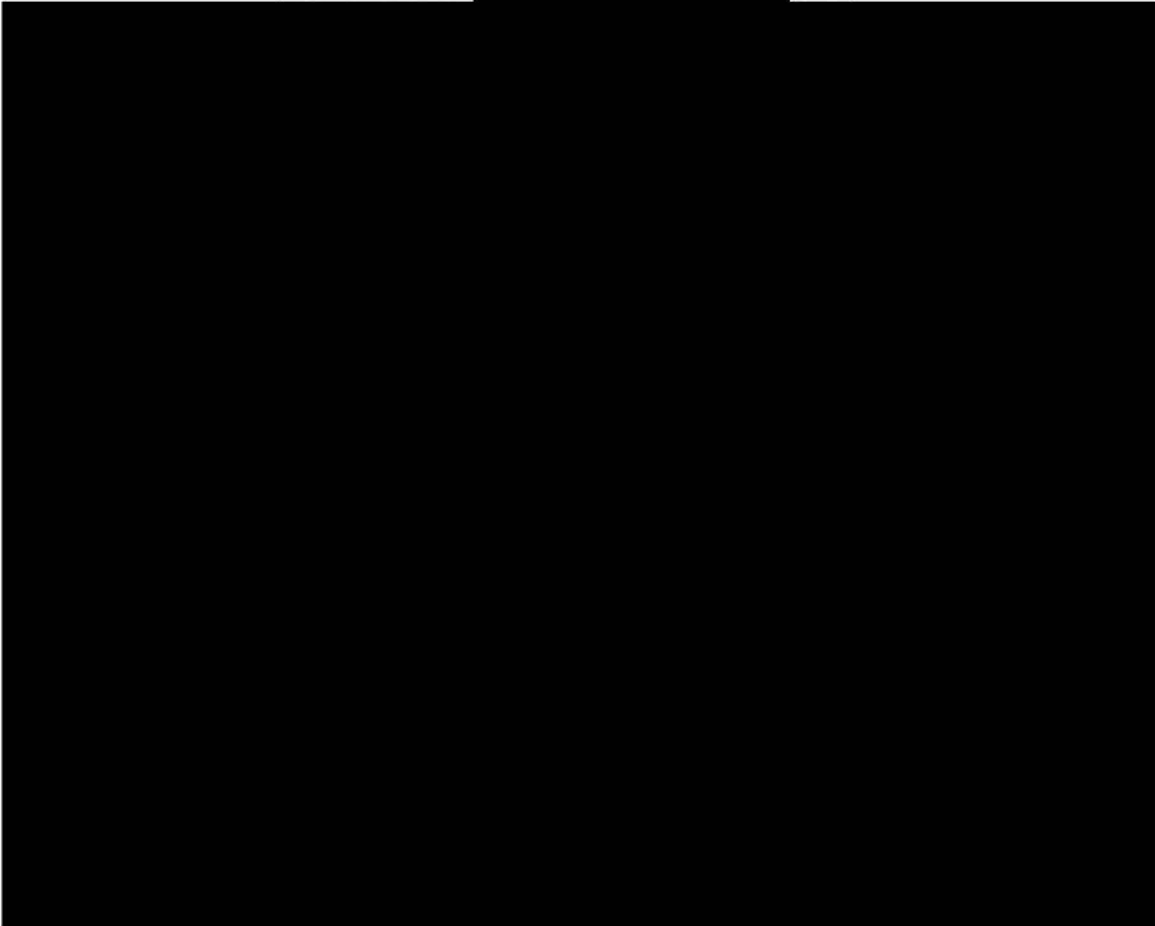
v.

KHALID SHAIKH MOHAMMAD;  
WALID MUHAMMAD SALIH  
MUBARAK BIN 'ATTASH;  
RAMZI BINALSHIBH;  
ALI ABDUL AZIZ ALI;  
MUSTAFA AHMED ADAM AL  
HAWSAWI

19 August 2024

AFFIDAVIT OF



Ph.D.



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- 
- 
7. Psychological testing involves the use of standardized questionnaires and self-report surveys that provide objective information about possible mental health diagnoses, personality structure, emotional states, and various psychological constructs and often, their severity. These data further inform an understanding of an individual's emotions, behavior, credibility of symptom report, interpersonal style and conflicts, vulnerabilities, strengths, and abnormalities.
  8. Neuropsychological testing, which is performance- and task-oriented, assesses different domains of cognition and their relationship to brain integrity and function (e.g., brain – behavior relationships). Such testing is the gold standard of the behavioral sciences for the precise assessment of functional cognitive deficits (and strengths), and their neuroanatomical correlates attributable to neurological disease, developmental disorders, brain injury, and psychological disorders.
  9. In the course of my career, I have evaluated a variety of litigants with reported histories of head injury and of emotional injury, in both criminal and civil litigation. My professional experience routinely integrates data from the medical record, historical antecedents, functional/everyday behaviors and subjective complaints of the examinee, the observations of collateral informants, assessment results of psychiatrists and other neuropsychologists, medical assessment from other physician colleagues, and neuroimaging evaluation from neuroradiologist colleagues. The responsibilities associated with such experiences include validity testing and accounting for the potential of malingering attendant to litigants, because of the secondary gain of the setting.
  10. I have been retained by the United States government to consult with them on a variety of questions relating to the prosecution of Mr. Ali. There are issues raised in the reports, declarations, and testimony provided by the Ali defense team, particularly from Dr. Hanrahan, Dr. Shea, and Dr. Gur, which I have reviewed in detail.
  11. Dr. Shea conducted psychological and neuropsychological testing and referenced it in his February 17, 2021 report, which I reviewed. In order to properly evaluate the results and impressions from Dr. Shea's neuropsychological report, I requested but did not receive the following:

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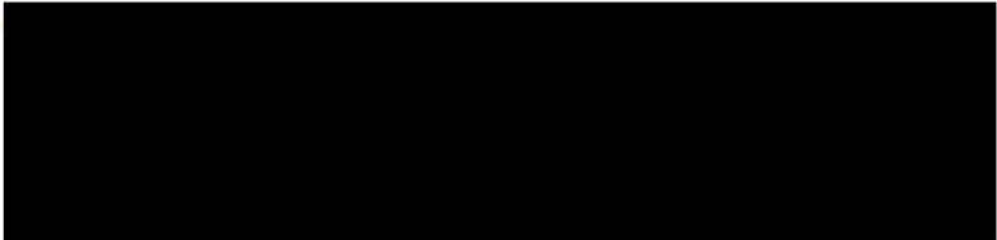


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- a. A list of which tests were administered on which days, the order of the tests administered, and the approximate start and stop times for testing on each day.
  - b. Any notations of behavioral observations during testing, including any notes that indicate the amount of time that Mr. Ali required to complete any non-timed tests and questionnaires/self-report measures.
  - c. Notes, if any, regarding the amount of sleep that Mr. Ali had the night before each day of testing.
  - d. The sources of the normative data used by Dr. Shea in determining the standard scores or percentiles of each test administered (e.g., the test manual, research articles, compendia of neuropsychological tests, or other ancillary references) for the Nelson-Denny Reading Test (Form H) and Short Category Test Booklet Form (1987 Manual).
12. Based on the claims raised by the defense, additional personality and emotional/psychological testing would be needed in order to assess Mr. Ali's symptom report, its validity, severity, potential origin, behavioral effects, and all diagnostic considerations.
13. It appears that the defense experts did not objectively explore in depth certain domains of function such as personality and psychological/emotional variables, as well as symptom validity that would be helpful to better understand factors that could be influencing Mr. Ali's symptom presentation.
14. Specific symptom validity testing measures are critical to include in forensic evaluations as these procedures are designed to assess the veracity of a patient's self-report with empirically derived cutoffs used to rule out exaggeration, embellishment, and malingering of subjective symptoms.
15. Because all self-report questionnaires and surveys are vulnerable to malingered symptomatology, some tests have "built in" or embedded symptom validity safeguards to identify exaggerated or embellished self-report. However, all questionnaires and symptom checklists do not contain these types of protections and so they are particularly vulnerable to symptom fabrication that may not be obvious even to trained clinicians. The Clinician Administered PTSD Scale (CAPS) is one such measure that does not include any symptom validity safeguards that could verify the authenticity of a person's self-report of PTSD symptomatology. Consequently, as with all such questionnaires, it too is susceptible to exaggerated symptom report.
16. There are some "stand alone" symptom validity tests that are designed with the sole purpose of detecting symptom fabrication and exaggeration. These types of symptom validity tests do not provide any meaningful clinical information about an examinee other than the probability of malingered self-report. [REDACTED]

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Consequently, it is important to administer multiple SVTs in an examination in which there is substantial reliance on an examinee's self-report rather than other, more objective data, and in which there is an incentive for a subject to embellish or fabricate symptoms.

17. A change in one's mental state at the time of injury or immediately thereafter is necessary to conclude that a person has sustained a brain injury. Just striking one's head does not constitute brain trauma or injury.
18. The length of unconsciousness, disorientation/confusion, loss of memory or rapid forgetfulness, and duration of said symptoms, need to be evident at the time of or immediately post-injury to determine the existence and severity of a traumatic brain injury.
19. 
20. 
21. Dr. Hanrahan asserted that during a 'walling' interrogation, Mr. Ali suffered "repetitive traumatic brain injuries...with insufficient recovery between injuries and in many cases milliseconds elapsing between injuries." However, this claim cannot be known with reasonable certainty. For example, it is unknown if Mr. Ali struck his head during the interrogation and if he did, how many times it occurred or what evidence there was that each strike resulted in a concussion. Importantly, a head strike does not mean that the brain was concussed. The presumption that he sustained a brain injury multiple times is unverifiable.
22. If a concussion is suffered, physical symptoms (such as headaches and dizziness) are ordinarily immediately apparent in the aftermath.
23. 

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24. Absent the emergence post-injury of another or additional neurologic conditions, the expected trajectory of one's symptomatology following a brain injury would generally reflect improvement or plateau, but not a worsening of neurologic symptoms over time.

25. Only when there are clusters of cognitive impairments, consistent with other historical, medical, behavioral, and functional records closer in time to an event, reflecting a convergence of the evidence, can a doctor be confident that a brain problem relates to a particular injury.

26.

27. Having a previous brain injury does not necessarily equate to permanent brain damage or long-term disability.

28. A neuropsychological examination that takes place years after the purportedly injurious event may have very little forensic value. It would be highly improbable that neuropsychological testing could link one's neurocognitive strengths or weaknesses to any injury that purportedly took place nearly seventeen years before, in the absence of unequivocal significant brain trauma, well established premorbid abilities, and baseline and serial neuropsychological testing conducted over time.

29.

30.

31.

32. It is common for neuro-healthy adults to exhibit significant variability between the highest and lowest scores within their own neuropsychological profiles, and that becomes more prevalent with the more tests you administer. Thus, abnormally low scores occur frequently within a neurologically normal population and thus cannot be interpreted as evidence of impairment without multiple low scores that cluster within the same cognitive domain.

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[REDACTED]

34. A brain image is not a behavioral or cognitive test that can directly predict executive functioning or any other cognitive ability. At most, some functional imaging may raise a suspicion of neuropsychological dysfunction, but does not prove that a functional ability is impaired.

35. It is misleading to apply MRI imaging to predict specific cognitive abilities as Dr. Gur attempts to do.

[REDACTED]

36. [REDACTED]

37. [REDACTED]

38. [REDACTED]

39. [REDACTED]

40. [REDACTED]

41. [REDACTED]

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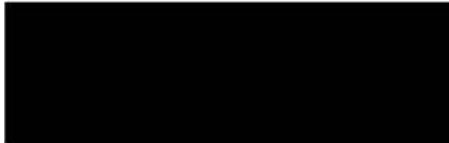
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FURTHER AFFIANT SAYETH NAUGHT



Ph.D.

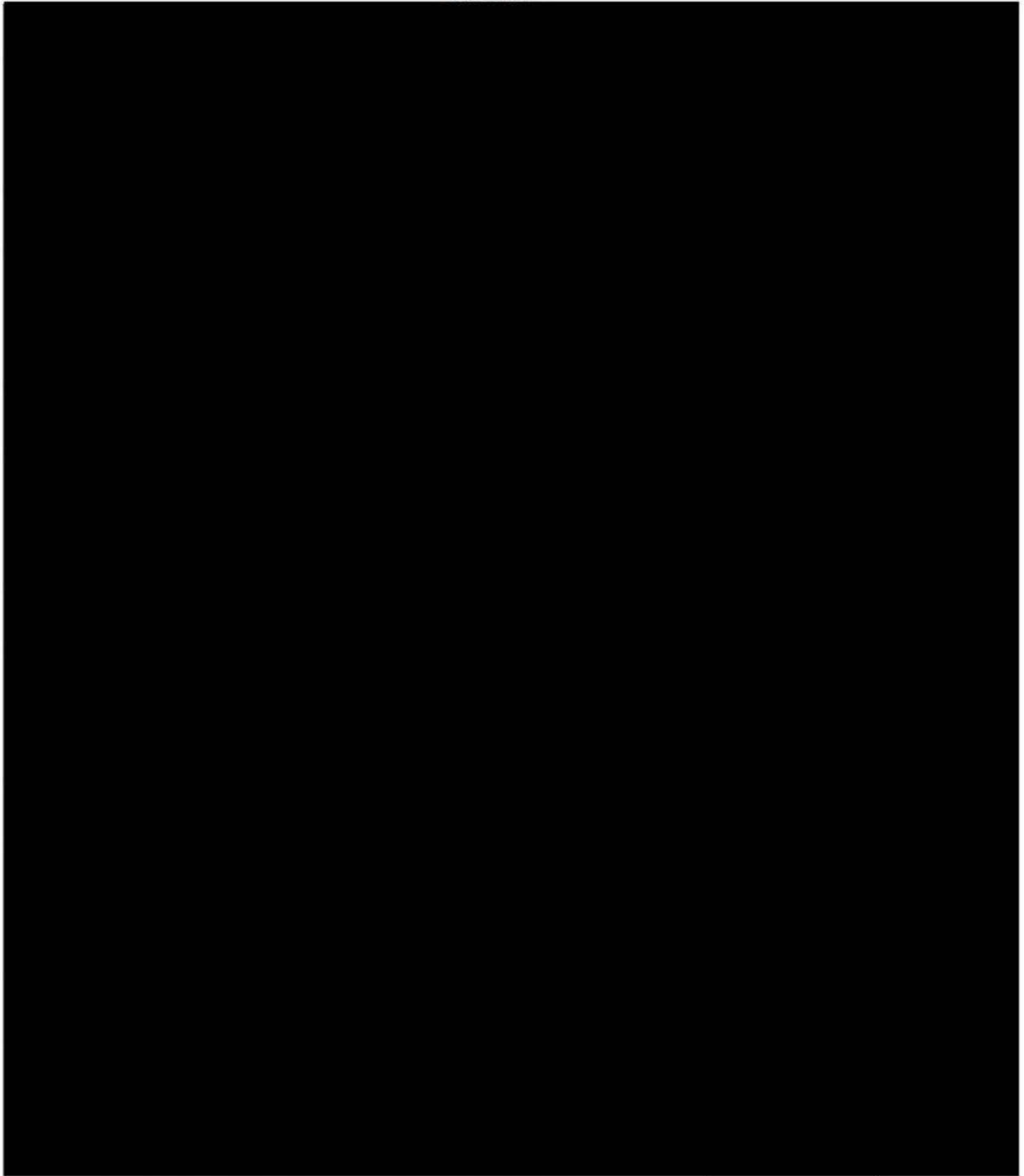
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# ATTACHMENT C

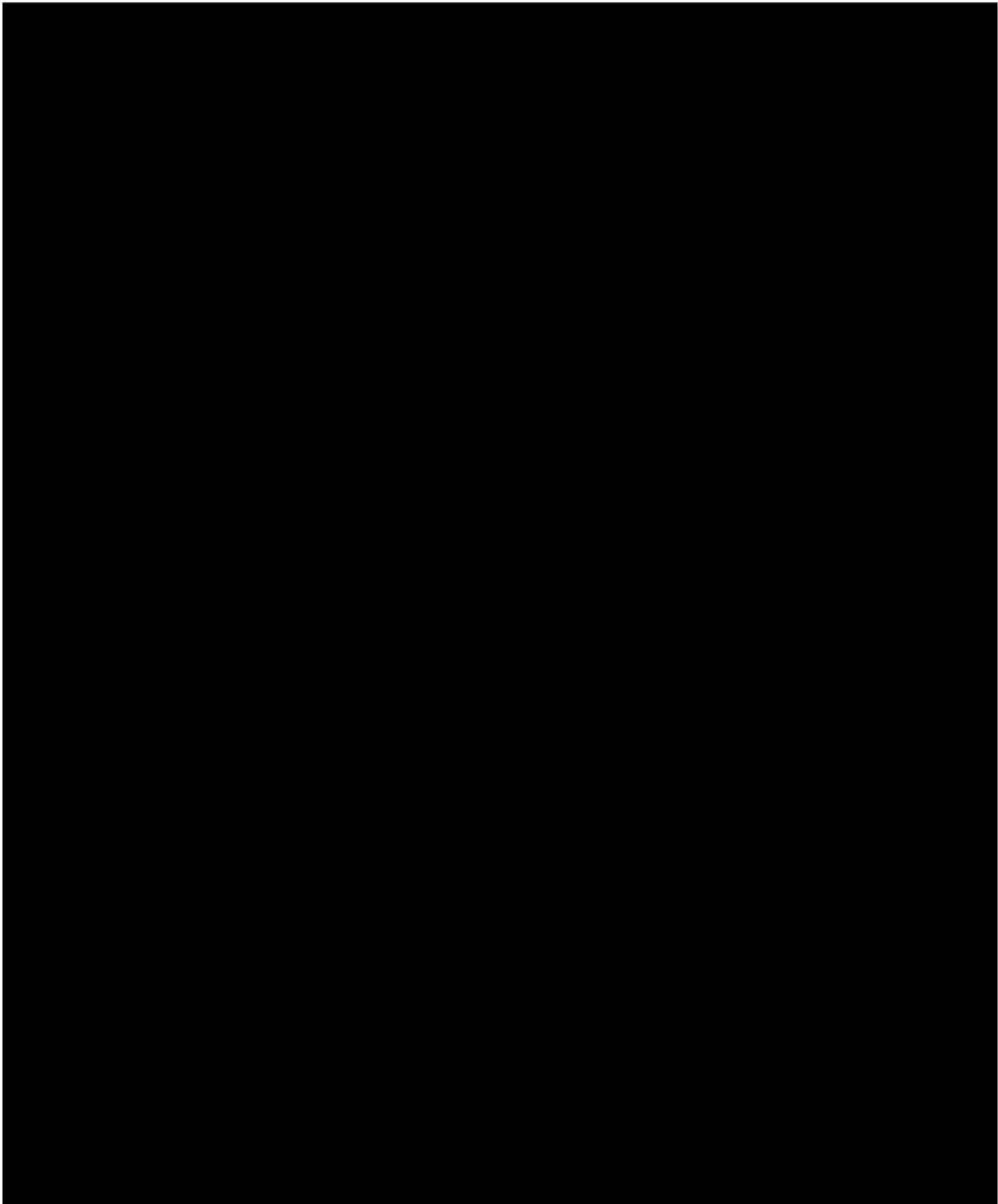
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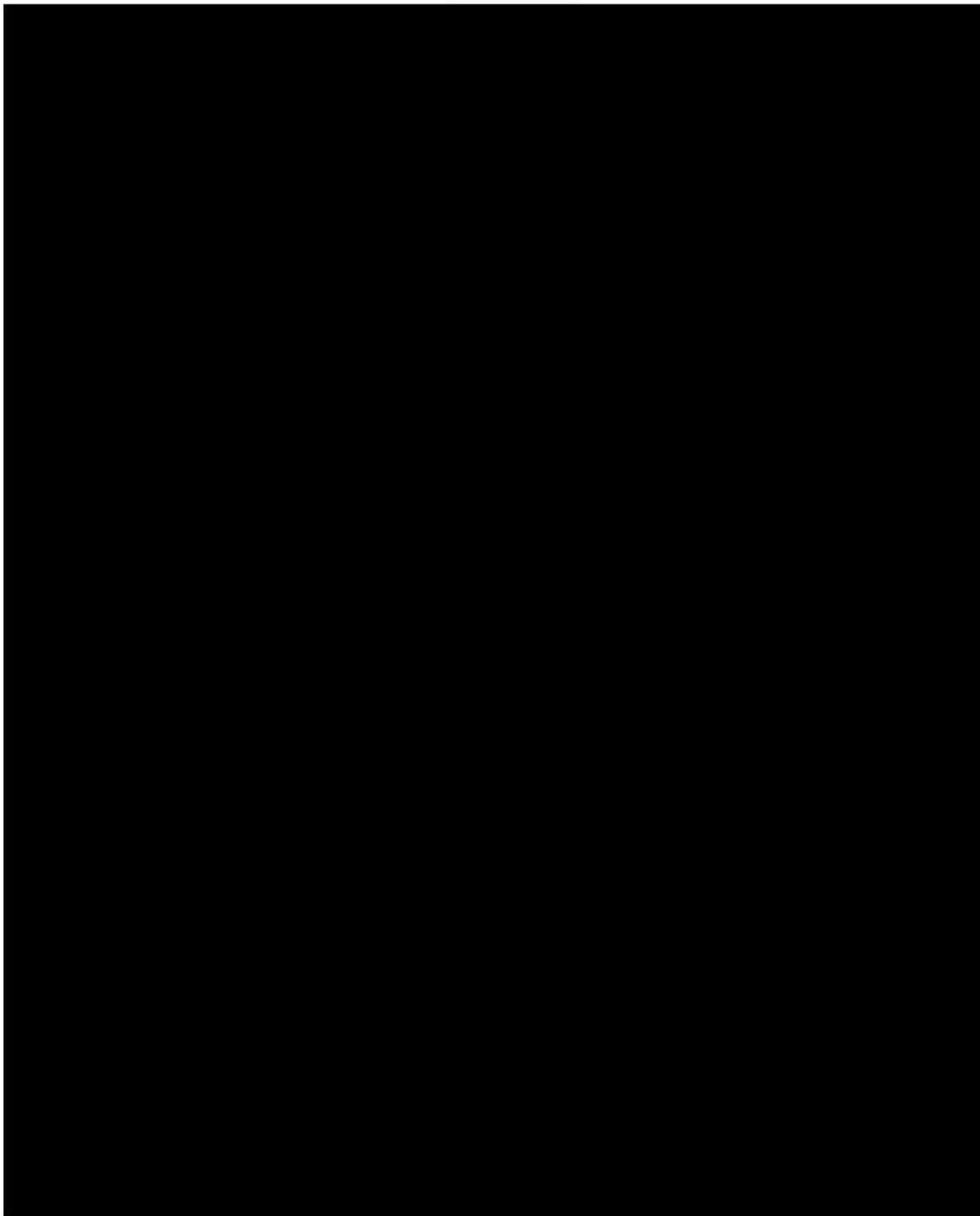




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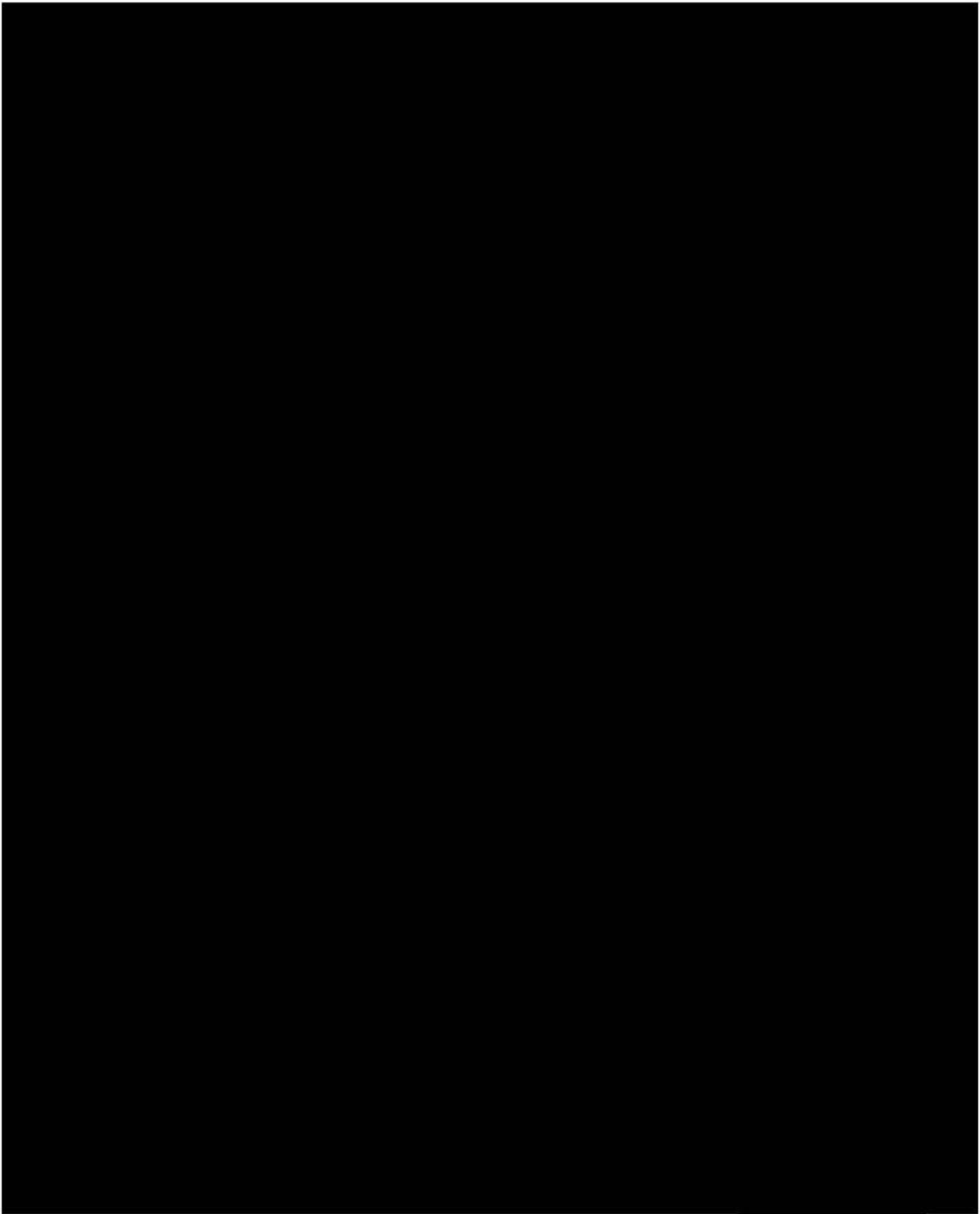


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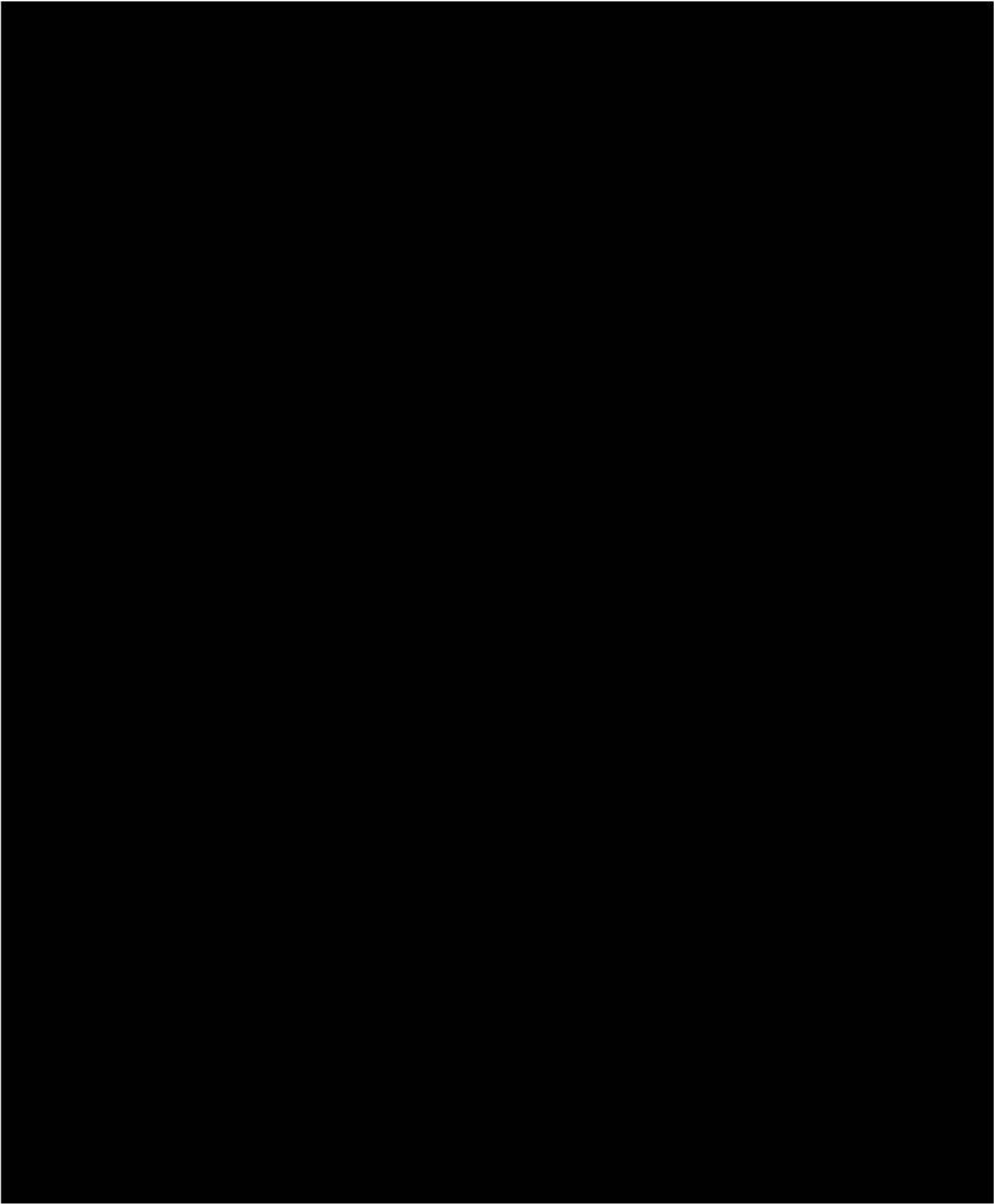
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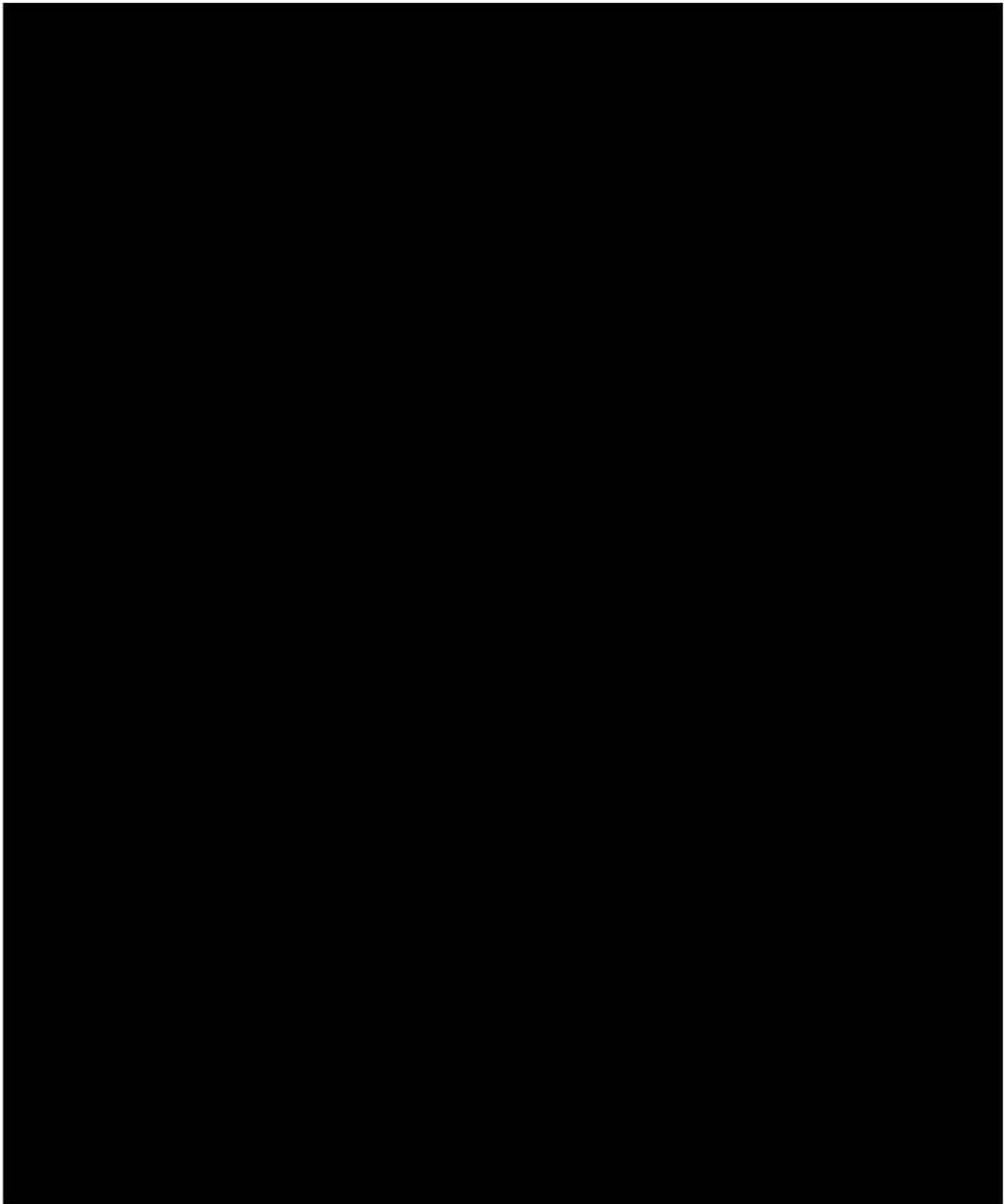




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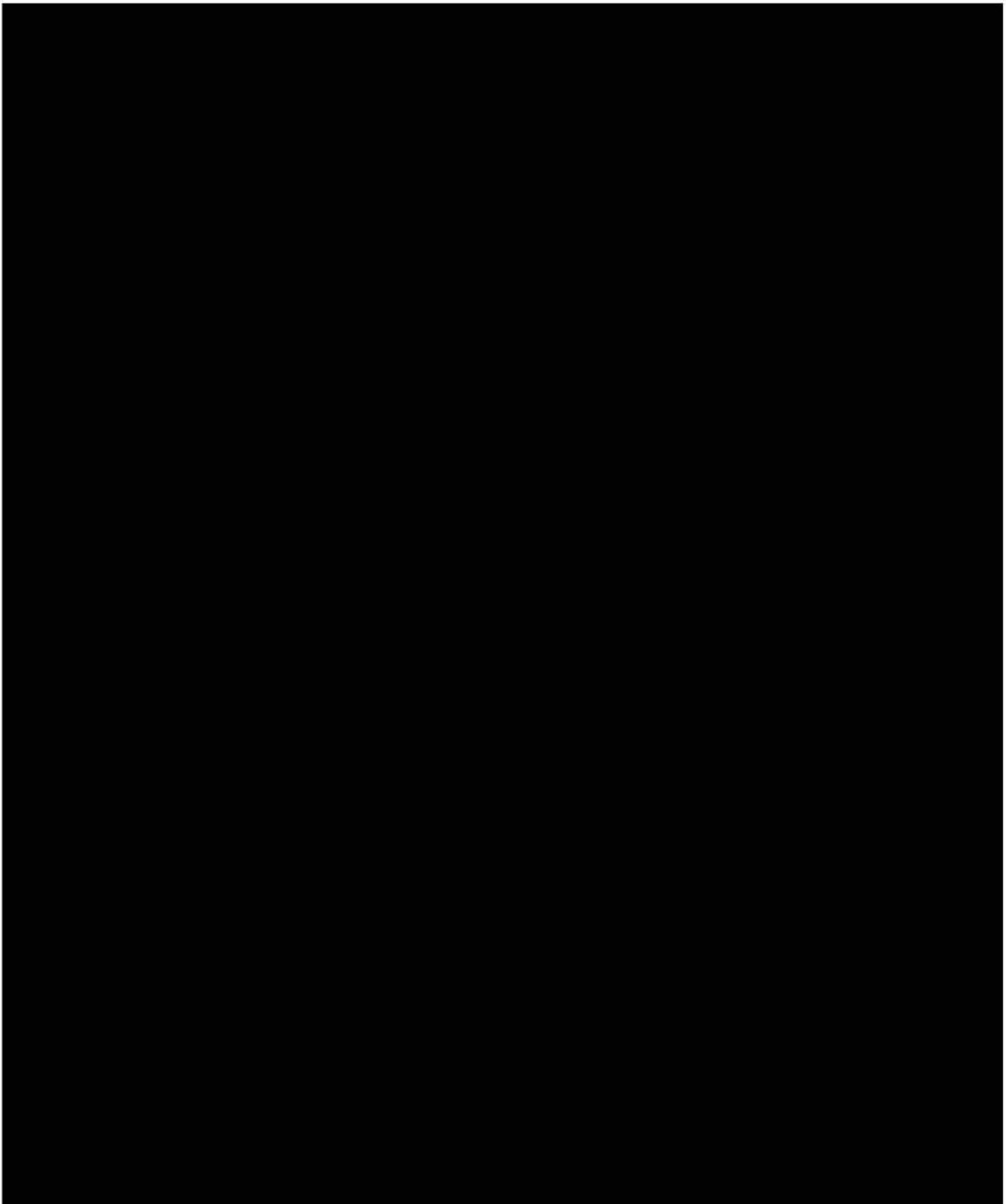




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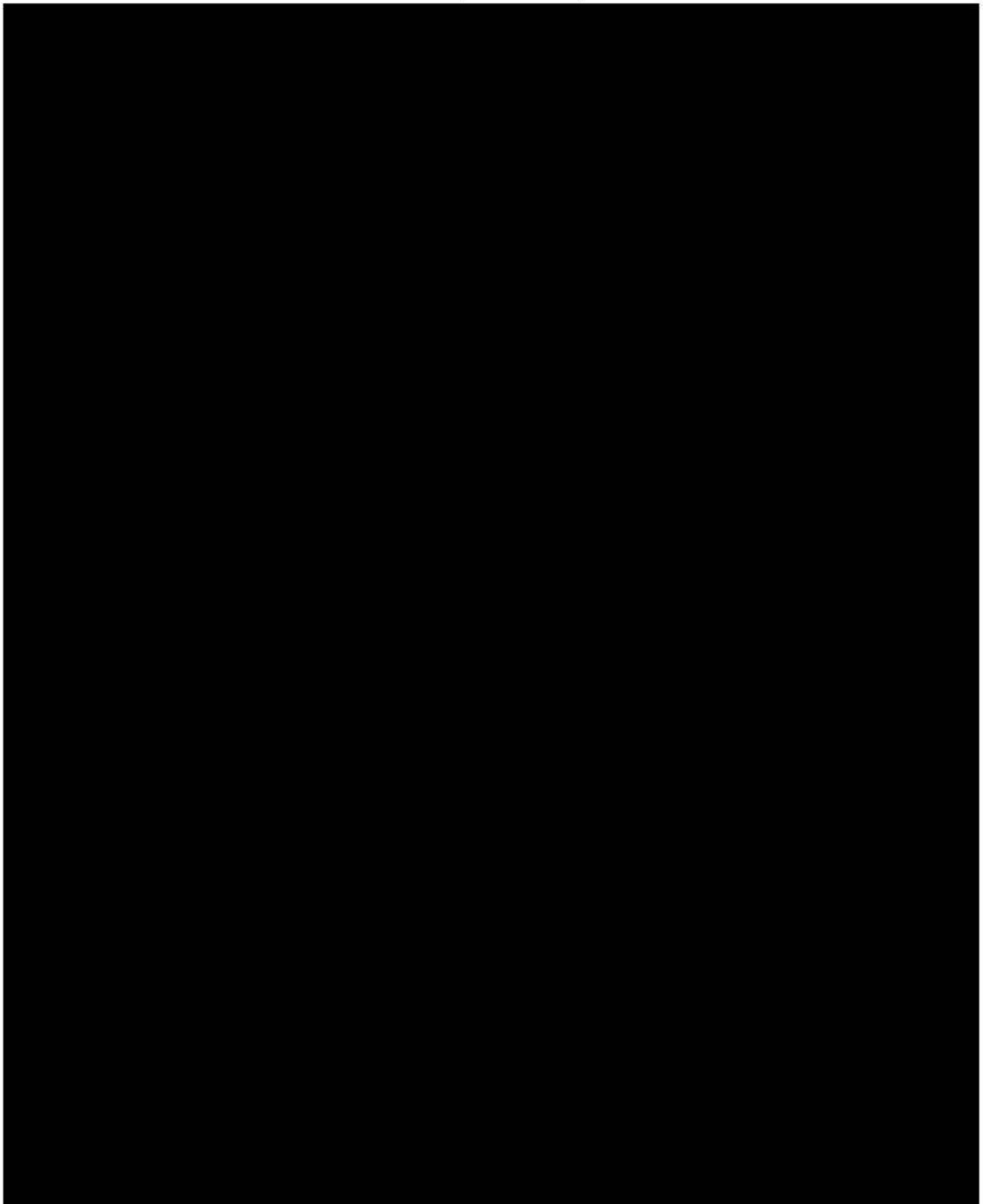




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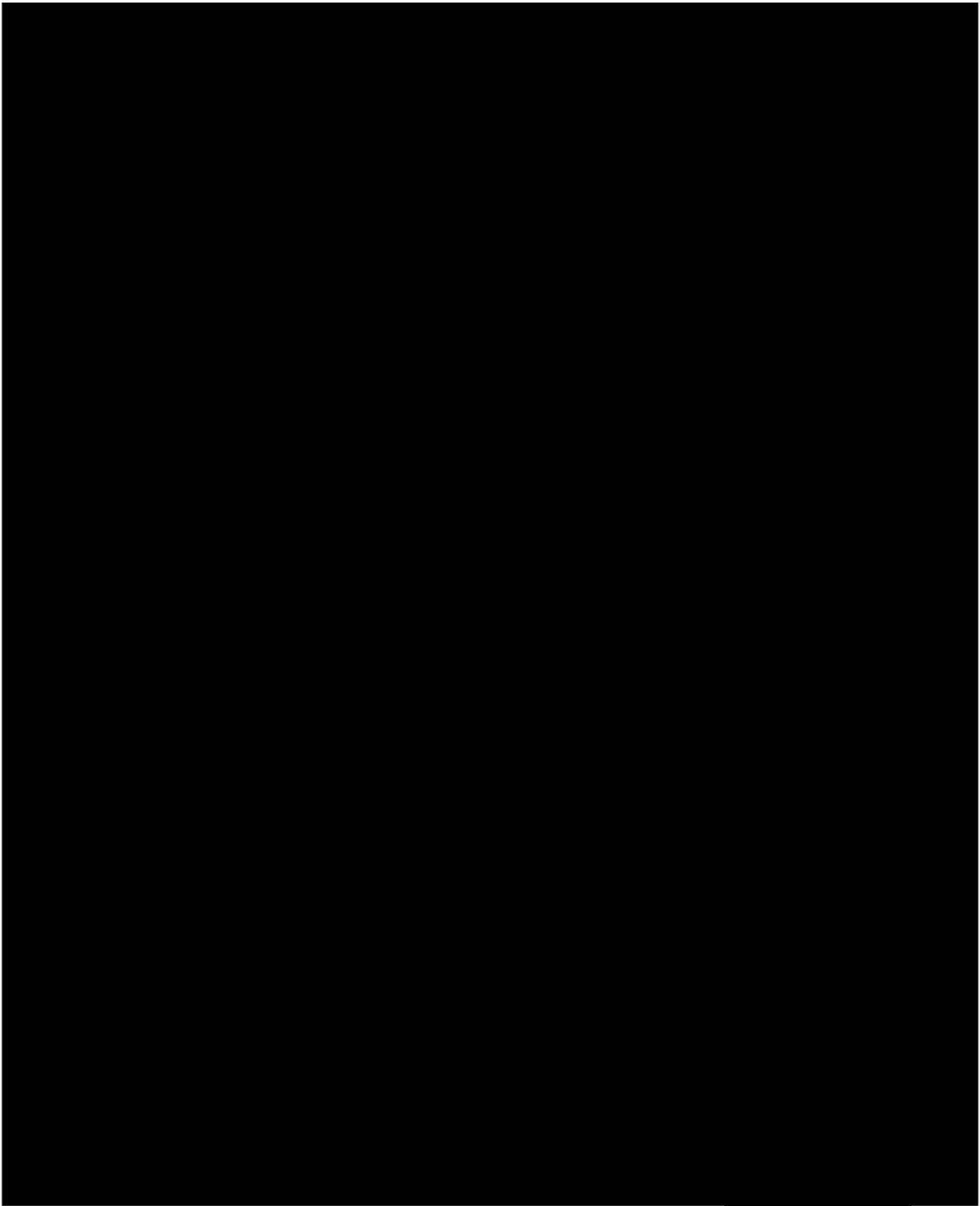
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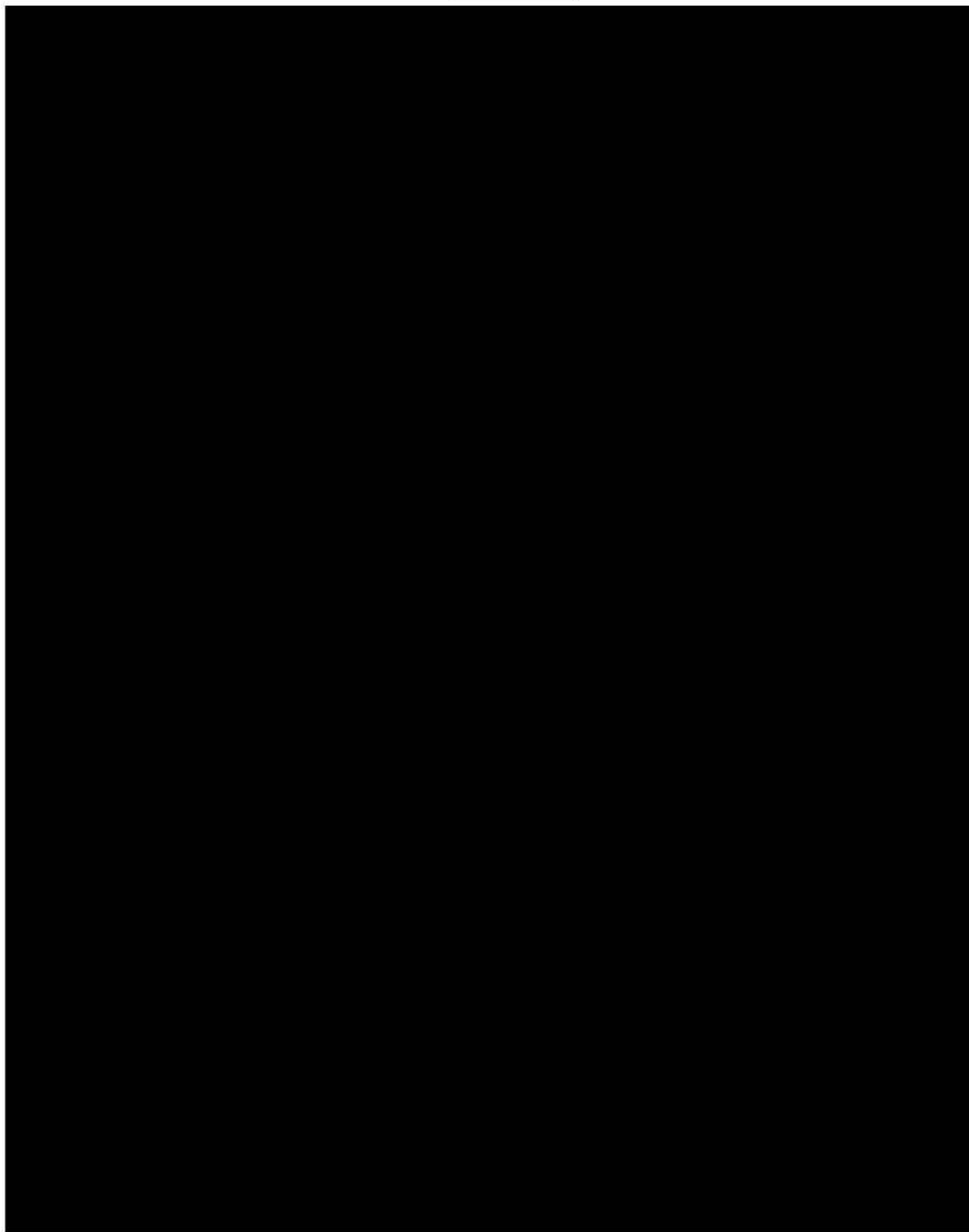
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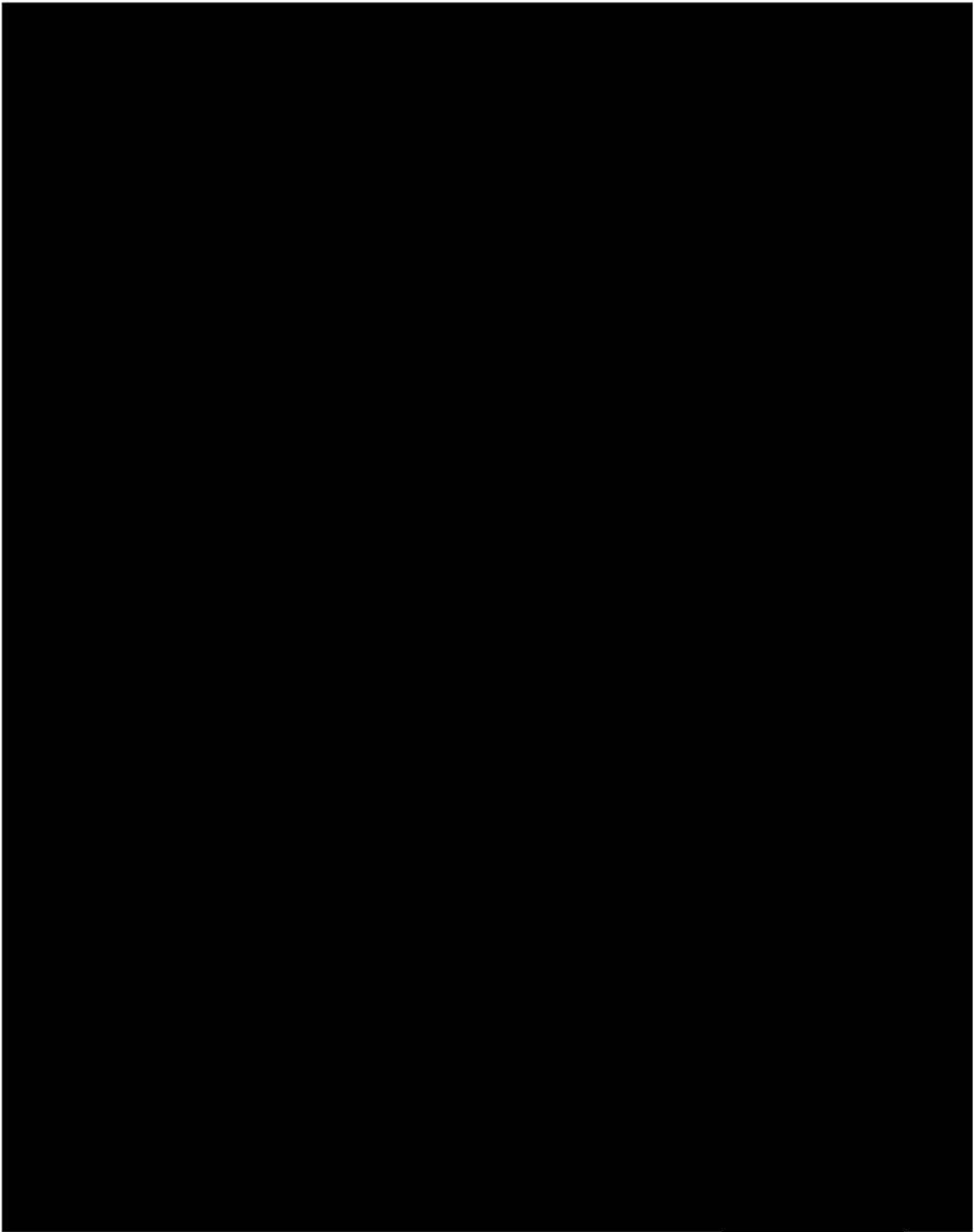


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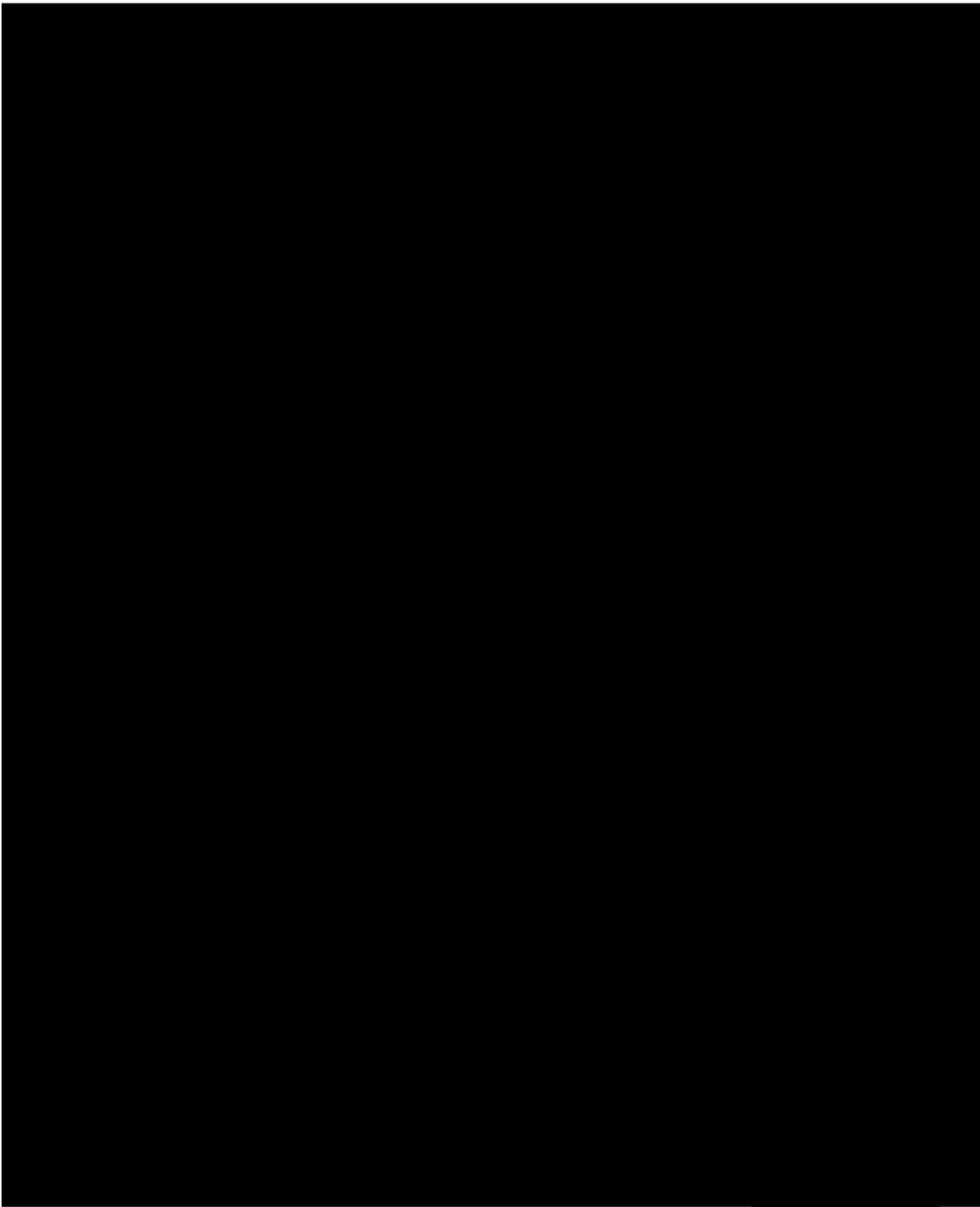
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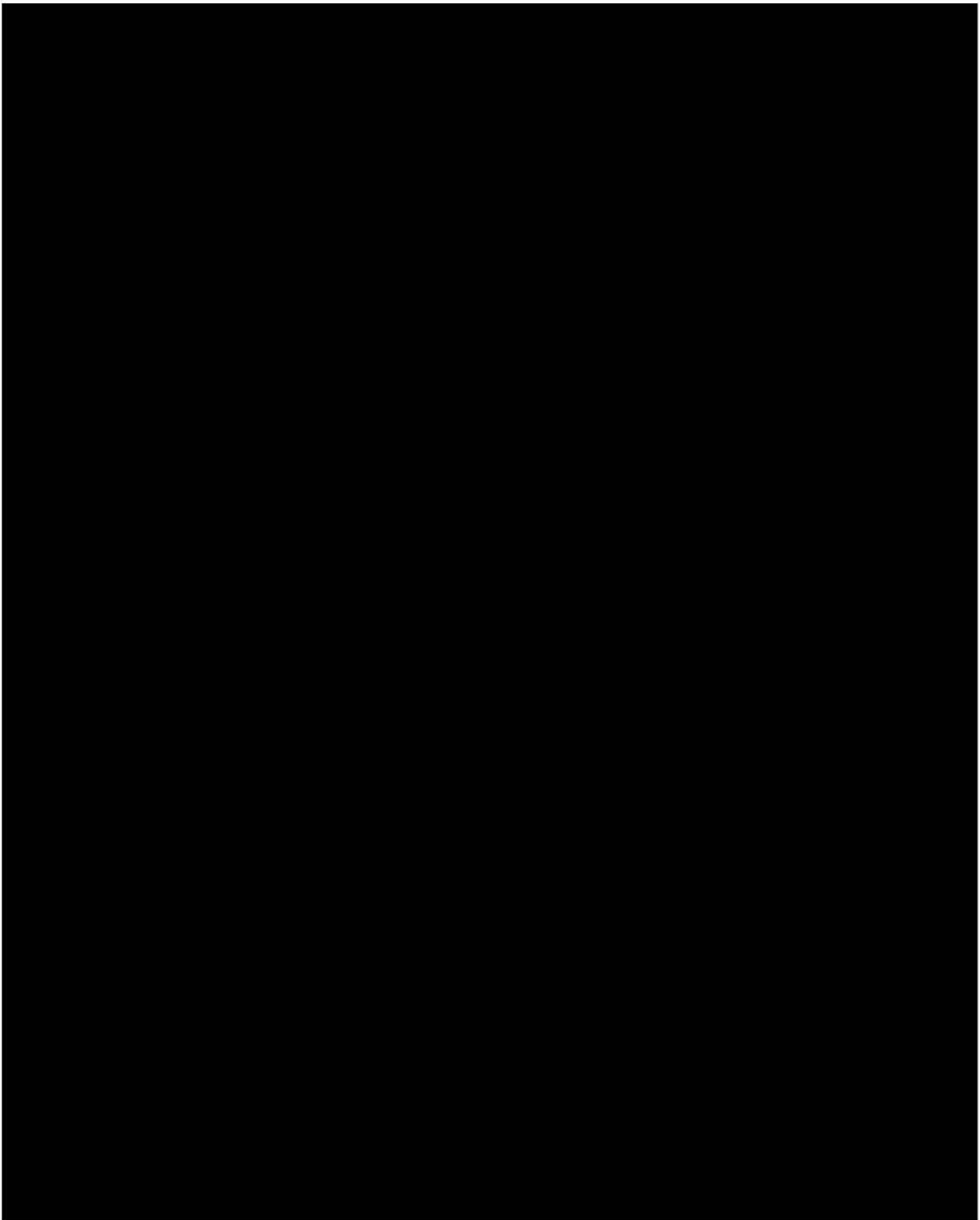


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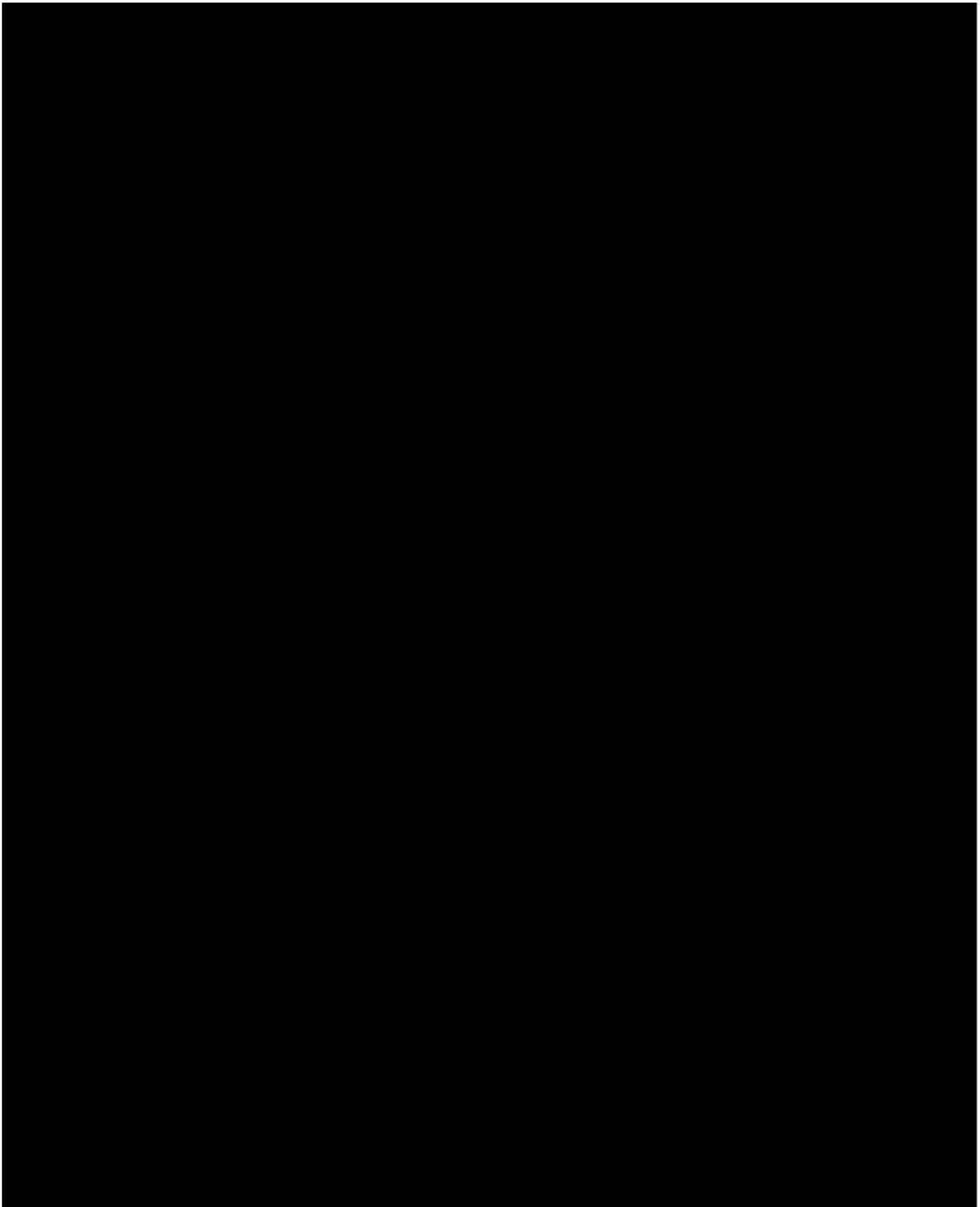


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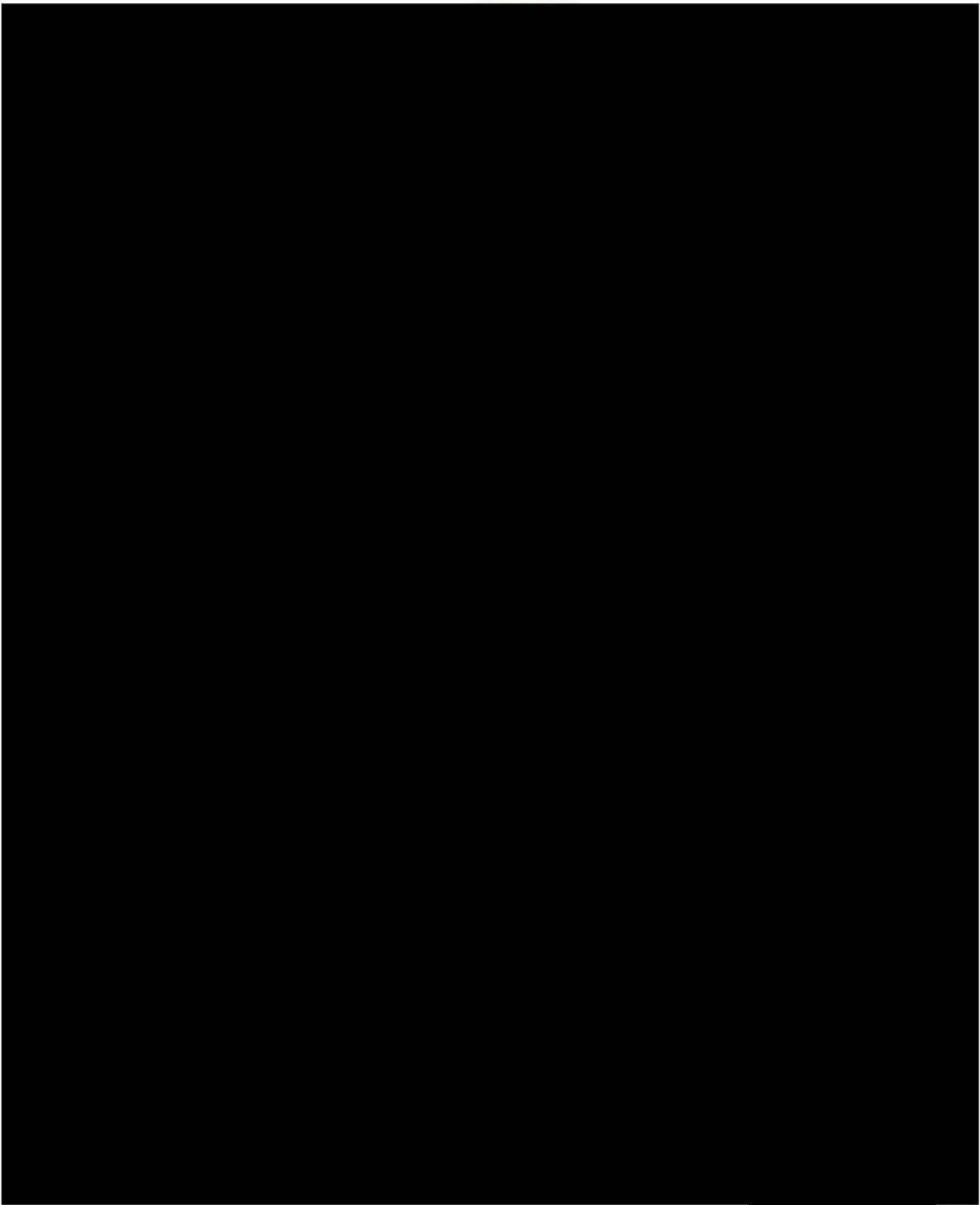


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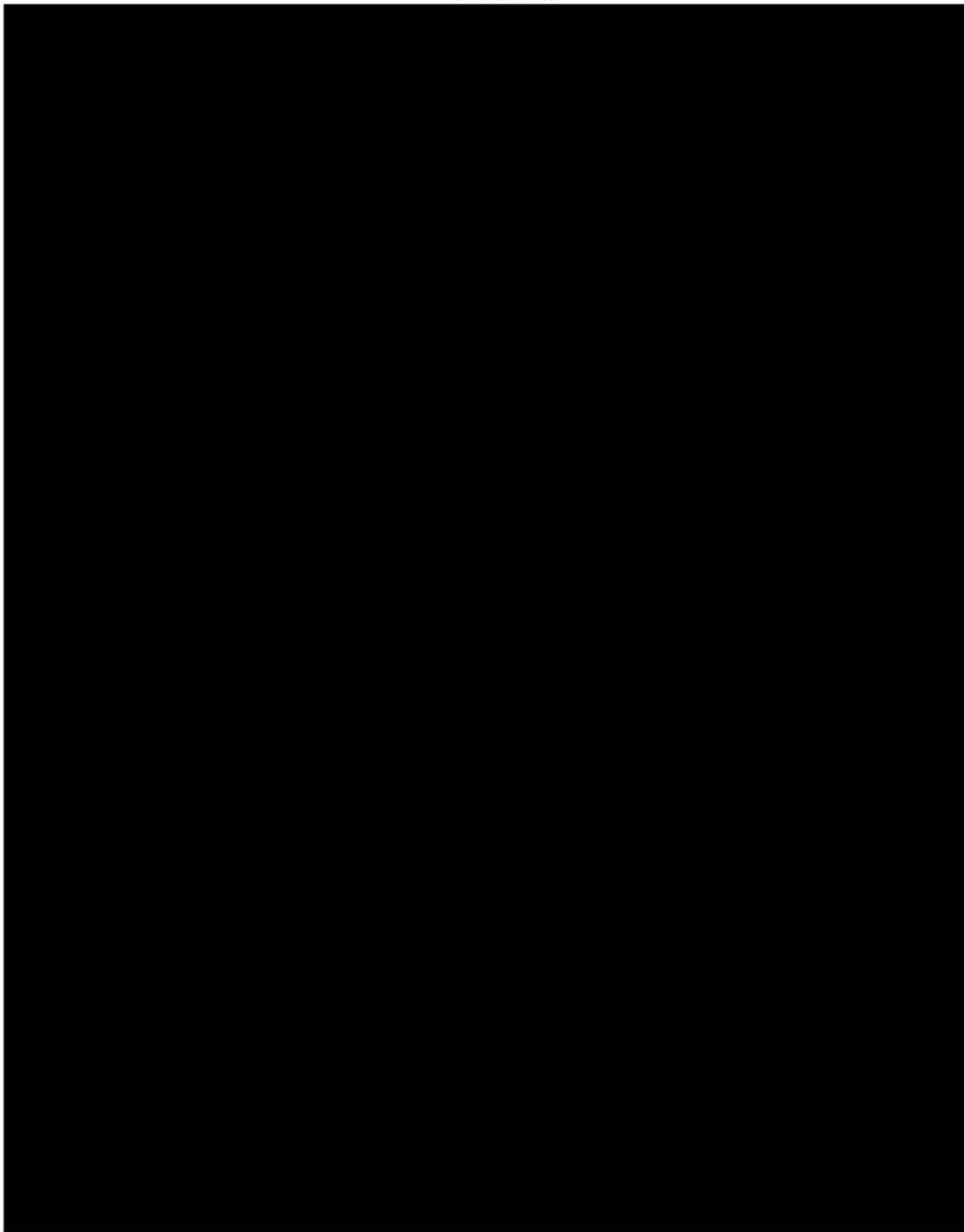
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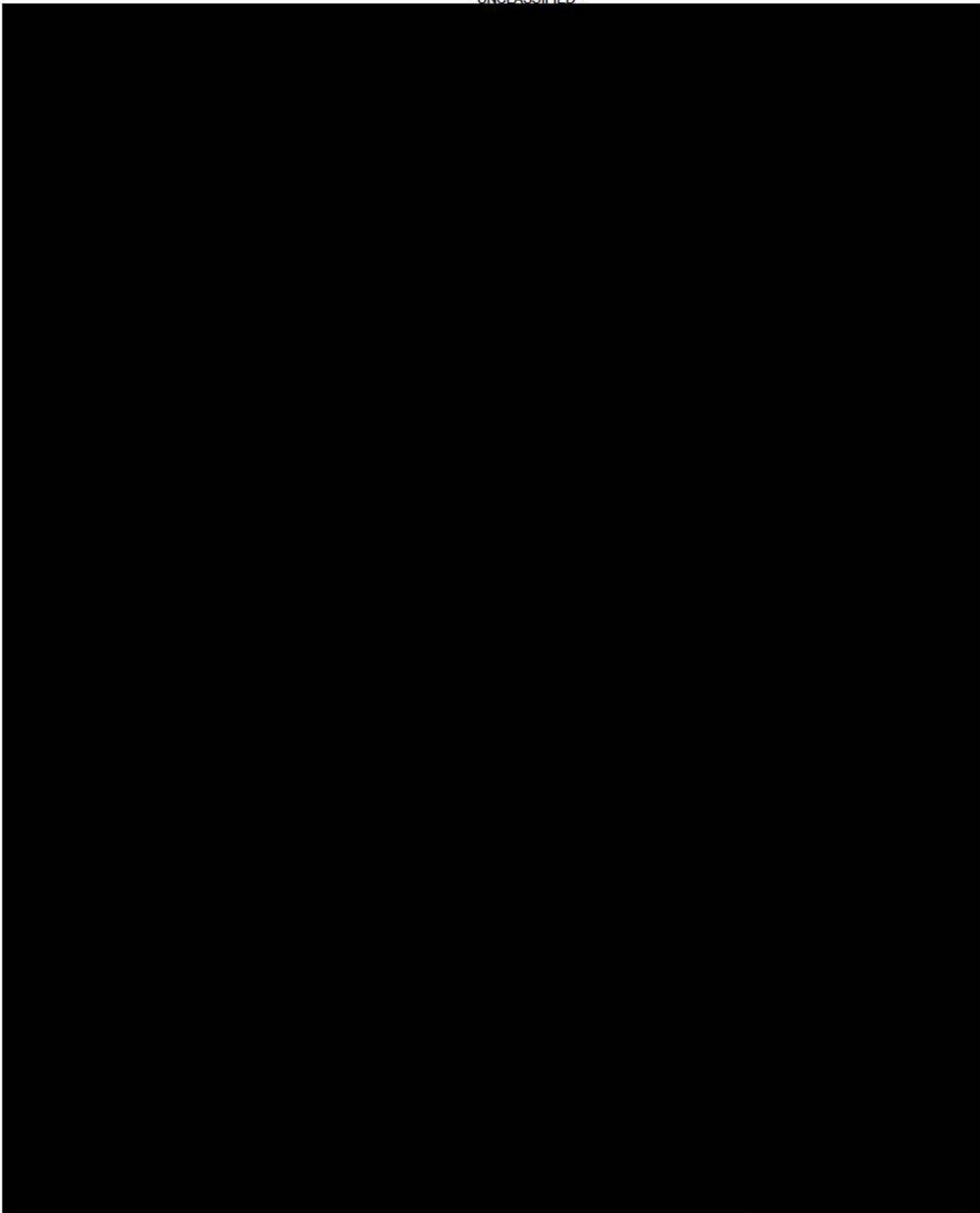


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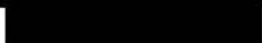


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